THE QUEEN'S MEDICAL CENTER

OUTPATIENT REHAB PATIENT INTAKE

PERSON COMPLETING THIS FORM:

☐ Patient ☐ Family (relationship): ______________ ☐ Other: ______________

Print Your Name: ______________________________

PATIENT NAME:	**DATE OF BIRTH:**

HEALTH HISTORY (Please circle/fill in)

STROKE (date): ______________	KIDNEY / BLADDER PROBLEMS: ______________
CANCER / TUMOR (date): ______________	EPILEPSY / SEIZURES
OSTEOPOROSIS	DIABETES (TYPE I / TYPE II)
PACEMAKER	HIV / AIDS
LUNG PROBLEMS: ______________	PSYCHOLOGICAL DISORDERS: ______________
HEART PROBLEMS: ______________	NEUROLOGICAL DISORDERS: ______________
BLOOD CLOTS / DVT	HEPATITIS (A / B / C)
HIGH BLOOD PRESSURE	ARTHRITIS (OSTEO / RHEUMATOID / GOUT)
TUBERCULOSIS	DIZZINESS
HEMOPHILIA	OTHER: ______________

DO YOU HAVE ANY SKIN (circle: LATEX / ADHESIVE) **ALLERGIES?** ☐ **YES** ☐ **NO**

HAVE YOU HAD ANY UNEXPLAINED WEIGHT LOSS OR GAIN RECENTLY (greater than 10 lbs)? ☐ **YES** ☐ **NO**

MEDICATIONS/SUPPLEMENTS/HERBS:

ALLERGIES:

RELEVANT SURGERIES/HOSPITALIZATIONS:

PRIOR RELEVANT INJURIES:

PREVIOUS TREATMENT FOR CURRENT PROBLEM:

OCCUPATION:

WORK STATUS: (Please circle) RETIRED UNEMPLOYED DISABILITY LIGHT DUTY MODIFIED DUTY FULL DUTY

LIVING SITUATION (Please circle): ALONE FAMILY CAREGIVER OTHER:

MODE OF TRANSPORTATION (Please circle): DRIVE PUBLIC FAMILY/FRIEND WALK

BRIEFLY DESCRIBE **YOUR PRIMARY PROBLEM:**

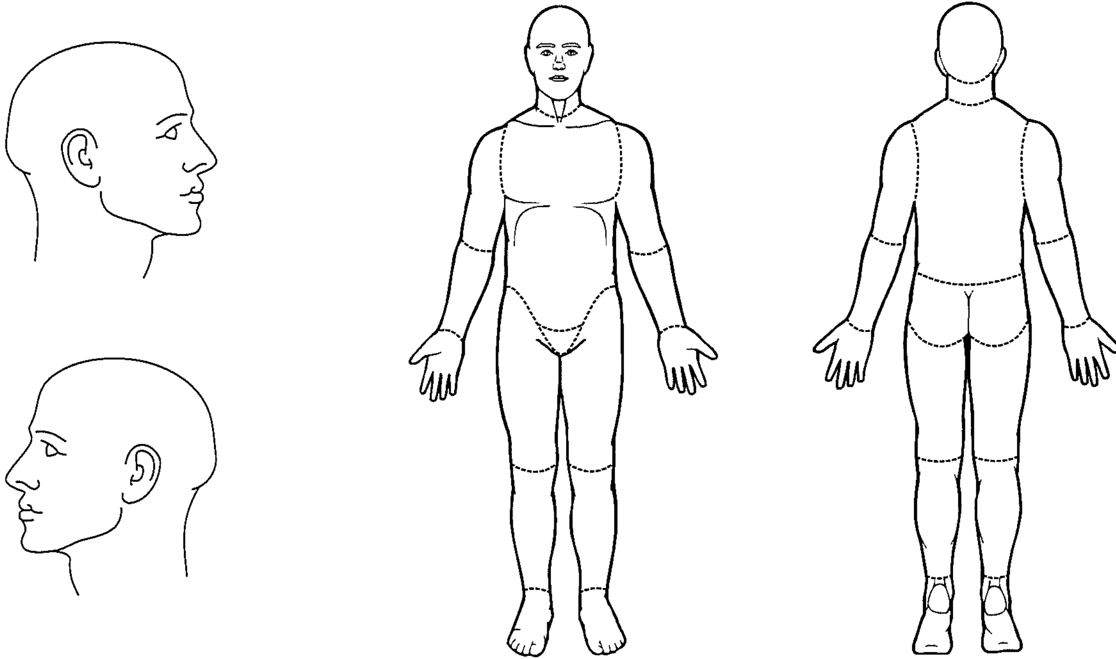
WHEN **DID YOUR PROBLEM START:**

HOW **DID YOUR PROBLEM START:**

WHAT MAKES YOUR PROBLEM WORSE (Aggravating Factors):

WHAT MAKES YOUR PROBLEM BETTER (Easing Factors):

PLEASE MARK SYMPTOMS (IE pain, numbness/tingling, weakness):



PLEASE FILL OUT BELOW ONLY IF YOU HAVE PAIN

PAIN SCALE (CIRCLE):

	(MILD)			(MODERATE)				(SEVERE)			
CURRENT:	0	1	2	3	4	5	6	7	8	9	10
BEST:	0	1	2	3	4	5	6	7	8	9	10
WORST:	0	1	2	3	4	5	6	7	8	9	10

DESCRIBE YOUR PAIN (circle): ACHING SHOOTING BURNING STABBING THROBBING

HOW OFTEN DO YOU EXPERIENCE PAIN (circle): CONSTANT SOMETIMES RARELY

WHEN IS YOUR PAIN THE WORST (circle): MORNING NOON NIGHT N/A